IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

June 16, 2015

Ms. Brandi Logli, Executive Director
Sunnybrook of Fairfield
3000 West Madison Avenue
Fairfield, IA 52556

RE: Final Recertification Monitoring Evaluation Report – Sunnybrook of Fairfield, Fairfield, IA

Dear Ms. Logli:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **May 28 & June 1, 2015.** The Report notes a Regulatory Insufficiency in the area(s) of: Life Safety.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0170** with effective dates of **February 19, 2015** through **February 18, 2017**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0170	A. BUILDING: _____ B. WING _____	06/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK OF FAIRFIELD	3000 WEST MADISON AVENUE FAIRFIELD, IA 52556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 46 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 51 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 9 TOTAL census of Assisted Living Program: 60 The following regulatory insufficiency was cited during the recertfication visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 138	481-69.32(2)a Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: a. Written procedures regarding alarm systems and appropriate staff response when a tenant ' s service plan indicates a risk of elopement or a tenant exhibits wandering	A 138		

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A 138	Continued From page 1 behavior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and Program documents the Program failed to have an operating door alarm system connected to each exit door in the dedicated dementia unit. The Program also failed to have written procedures regarding the alarm system and appropriate staff response when a tenant's service plan indicated a risk of elopement or a tenant exhibited wandering behavior. A door in the dedicated dementia unit was not alarmed and was unlocked when observed during the tour of the building. The Program also did not provide written procedures regarding the alarm system and staff response when a tenant's service plan indicated risk of elopement or when a tenant exhibited wandering behavior. 1. According to the ALP Monitoring Entrance Form, the Program consisted of a dedicated dementia unit with 9 tenants and a general population, which was dementia specific by definition, with 51 tenants at the time of the recertification visit. The dementia unit was required to be alarmed as it was a dedicated dementia unit. The general population was dementia specific by definition; however, at the time of the recertification visit was not required to have operating door alarms. 2. According to observations on 5-28-15 and 6-1-15, the dedicated dementia unit had four exits (for the purposes of the report the doors were assigned number to provide clarification). Door #1 was a delayed egress door and the door went to the exterior of the building. Door #2 was a	A 138		

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A 138	Continued From page 2	A 138		

delayed egress door and was located in the 500's hallway of the building. Door #2 was located between the general population and the entrance to the dedicated dementia unit. Door #3 was a delayed egress door and was located in the 300's hallway of the building. Door #3 was located between the general population and the entrance to the dedicated dementia unit. Door #4 was a door that went from the dedicated dementia unit to the courtyard. Door #4 was not a delayed egress door and was not alarmed.

The building had a courtyard which was enclosed by the structure. There were three doorways from the courtyard, including Door #4 into the dedicated dementia unit. There were two other doorways from the courtyard that went into the general population. Door #5 was located in dining room and went into the courtyard. The door had delayed egress capabilities; however, when observed the door opened without delayed egress and was not alarmed. Door #6 was located in the transition between the 400's hallway and 500's hallway. The door was not a delayed egress door and was not alarmed. The dedicated dementia unit and general population had exit doors that went to the courtyard. That provided an area where two different populations, tenants in the dedicated dementia unit and tenants in the general population, both had access.

3. On 5-28-15 at approximately 11:20 a.m. a tour of the building was completed and the following was observed: the door from the dementia unit to the courtyard (Door #4) was unlocked and not alarmed. The locking hardware was located on the inside of the door and the bar was the outside of the door. According to observations on 5-28-15 and 6-1-15, the monitor was able to enter

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A 138	Continued From page 3 the courtyard through the doors at the transition from the 400's hallway and 500's hallway (Door #6) and enter the building from the courtyard through the doors in the dining room (Door #5) without any alarms sounding or security code required. 4. According to an interview on 6-1-15 with the Environmental Services Director, the door from the dedicated dementia unit to the courtyard (Door #4) was usually locked. He said the plan for the door was to disable the locking hardware and to make the door a fixed non-operable viewing point. 5. According to an interview on 6-1-15 with the Executive Director, the door observed unlocked on the tour (Door #4) was usually locked. Staff had a key for the door on the key ring, which was exchanged by staff at shift change. She said there was no audible alarm to the door and staff was not alerted when the door was opened. There were no policies on door alarms. The Executive Director said there had been no issues with tenant elopements or fire. 6. According to the Program's policy regarding mandatory safety in a dementia unit, a secured dementia unit would have locked doors which were opened with a security code. The doors would also have a 15 second delay for egress. Evacuation of the tenants to the other side of the two hour fire doors would occur if a fire was in the dementia unit. If the fire was outside the dementia unit the tenants would remain in the area. In case of an emergency evacuation staff would remain with tenants at all times. 7. According to the Program's policy regarding employee training, during the orientation process	A 138		

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A 138	Continued From page 4 employees would receive training including: fire and storm safety training.	A 138		

Sunnybrook of Fairfield Assisted Living
3000 W. Madison,
Fairfield, IA 52556
Tel: 641-469-5778
Fax: 641-469-4529

June 22, 2015

Rose Boccella

Program Coordinator

Adult Service Bureau

RE: Final Recertification Monitoring Evaluation Report

Dear Ms. Boccella:

Life safety 481-69.32(231 C) Attached are the emergency policies and procedures and structural safety requirements.

Life Safety 69.32- An audible alarm system for the door in the dementia unit labelled as; Door #4 will be installed with an audible alarm. The project will begin approximately June 30, 2015 and will be completed by July 15, 2015. The door alarms are inspected monthly by maintenance.

Sincerely,

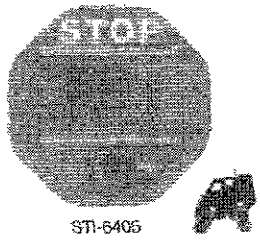
Brandi Logli

Executive Director

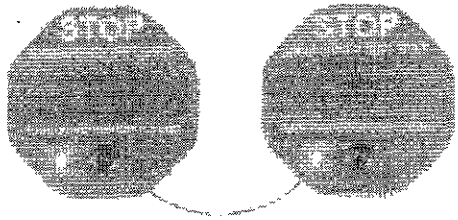
THEFT PREVENTION

STI EXIT STOPPER®

STI-6400



STI-6405



STI-6406

PRODUCT OVERVIEW

The highly effective Exit Stopper can serve as an inexpensive security device and help stop theft by alerting you to any unauthorized exits or entries through emergency exit doors.

HOW IT WORKS

If the protected door is opened, the electronic Exit Stopper emits an ear piercing alarm for 30 seconds, 3 minutes or continuously (as preset by the user). A key operated override will silence the alarm and allow authorized exits. The unit can be set for a 30 second delay before arming or tripping. Exit Stopper "Always Active" allows the key holder to reset the alarm, but does not allow the alarm to be turned off. Exit Stopper is fitted with a 9 VDC alkaline battery. It is available in red or green for almost any type of door, mounting or installation, including remote placement of the alarm (not for outdoor use).

KEY FEATURES

General Information

- Alarm alerts to any unauthorized exits/entries through emergency exit doors and rear doors.
- User can select whether to use as an alarm or annunciator.
- 105 or 95 dB warning horn.
- Detects both unauthorized exits and entries.
- Three year guarantee against breakage of polycarbonate in normal use (one year on electro mechanical and electronic components).

Design

- Highly visible "stop sign" design acts as a deterrent.

Construction

- Tough, ABS construction.

Installation

- May be mounted on top, right, left or next to almost any door.
- Recommended operational temperature range is 32° to 113°F.
- Not for outdoor use.
- Unit is completely self-contained.
- Easy to install...much less expensive than heavy horizontal bar type units...and practical for all emergency doors.

Electronics

- In exit alarm mode, alarm can be set to sound for 30 seconds, 3 minutes or indefinitely (unless disarmed with key supplied or until battery is drained).
- In annunciator mode, it announces door entry with a set of 10 beeps.
- May be programmed for 30 second entry delay or immediate alarm.
- Arming delay allows unit to arm following authorized exits.

Options

- Available in red or green.
- STI-6400WIR supervised wireless 433 MHz (with 4 or 8-Channel Receiver or Voice Receiver). Up to 1000 foot (line of sight) range.
- STI-6402 provides protection for double door applications with two sets of reed contacts
- STI-6403 allows for remote horn to be located 300 feet from the door it is protecting - 18 gauge wire not included or electrically supervised.
- STI-6404 provides protection for double doors and has remote horn capabilities (18 gauge wire not included).
- STI-6405 allows key holder to reset the alarm, unit cannot be turned off.
- STI-6406 can be operated from both sides of the exit/entry door.

For more information, call 1-800-888-4784 (4STI) or visit [illegible]

Safety Technology International, Inc.

STI Exit Stopper®

Dimensions and Technical Information

MODELS AVAILABLE

STI-6400	Exit Stopper multifunction door alarm
STI-6400WIR	Wireless Exit Stopper multifunction door alarm
STI-6400WIR4	Wireless Exit Stopper multifunction door alarm with 4-Channel Receiver
STI-6400WIR8	Wireless Exit Stopper multifunction door alarm with 8-Channel Receiver
STI-V6400WIR4	Wireless Exit Stopper multifunction door alarm with 4-Channel Voice Receiver
STI-6402	Exit Stopper multifunction door alarm for double door installation
STI-6402WIR	Wireless Exit Stopper multifunction door alarm for double door installation
STI-6403	Exit Stopper multifunction door alarm with remote horn
STI-6404	Exit Stopper for double door with remote horn
STI-6405	Exit Stopper multifunction door alarm with "always active" feature
STI-6406	Exit Stopper with dual access control
STI-6453AED	Replacement siren alarm
STI-34104	4-Channel receiver
STI-34108	8-Channel receiver
STI-30104	Lamp controller
SUB-6403	Remote horn to use in conjunction with all above exit alarm models or to replace remote horn in STI-6403
06402	Magnet and reed switch with spacers
16200	Warning "Door Alarmed" label

APPROVALS & WARRANTY

TESTING

STI-6400, STI-6400WIR, STI-6400WIR4 & STI-6402WIR

- FCC & IC Compliant
- CE Approved

WARRANTY

Three year guarantee against breakage of polycarbonate in normal use (one year on electro mechanical and electronic components).

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Volume- (105 dB) at 1 foot	ON*			
Volume- (95 dB) at 1 foot	OFF			
Duration - 30 Second Alarm		OFF*	OFF*	
Duration- 180 Second Alarm		OFF	ON	
Duration- Continuous Alarm		ON	OFF	
Duration- Annunciator Mode		ON	ON	
Trip- Immediate			OFF*	
Door Prop Mode			ON	
Arming- Immediate				ON*
Arming- 30 Second Delay				OFF

**Factory Settings*

SPECIFICATIONS

Housing	1/8 in. Polycarbonate
Power Source	9 VDC Alkaline or 12-24 VDC Wired
Warning Horn	95 dB - Low
at 1 foot	105 dB - High
Relay Contacts	Form C Dry 0-30 Volts AC/DC, 1 Amp
Dimensions	5.375 in. x 5.375 in. x 2 in. 137mm x 137mm x 51mm
Standby Current	10 uA
Alarm Current	200 mA
Recommended Operating Temperature	32°F to 113°F (0°C to 45°C)

Safety Technology International, Inc.

2306 Airport Road
Waterford, Michigan
48327, USA

Tel: 248-673-9898
Fax: 248-673-1246
Toll-free: 800-888-4784
info@sti-usa.com
www.sti-usa.com

Unit 49G Pipers Road
Park Farm Industrial Estate
Redditch, Worcestershire
B98 0HU England

Tel: 44 (0) 1527 520 999
Fax: 44 (0) 1527 501 999
www.sti-europe.com

20. Elopement Risk (MC Only)

Purpose:

To establish a systematic approach for identifying residents who are at high risk for elopement and to establish a procedure to ensure the safety of a resident who may wander. To establish a staff and family education process to ensure all appropriate persons are aware of the elopement precautions that need to be followed.

Policy:

Upon move in to a memory care unit, all residents need to have an elopement evaluation. Any resident identified at risk, of elopement should have every attempt made to have some type of ID on their person containing their name, address and phone number. This could include a stainless steel or medical ID bracelet or an Alzheimer's *Never Lost* bracelet. All residents will have their picture available.

Any resident residing in an ALF community who exhibits goal directed (exit seeking) wandering and becomes at risk for elopement will require an elopement risk evaluation. Upon any suspected or actual missing person in an ALF community, an elopement risk evaluation will be done and a plan of care meeting held to identify the safety needs of the resident.

All interventions will be identified on the resident's Plan of Care and all staff will be made aware of those interventions. All staff will receive in-service/training on how to respond in the event of an elopement.

Procedure:

Upon move in to the memory care community, use the Elopement Risk Evaluation as a tool to identify anyone at risk for elopement. Re-evaluate quarterly if elopement risk continues.

1. Assure all exit doors are alarmed properly and remain on, 24 hours a day.
2. Door codes should be changed periodically in case there are residents that can manage the door codes.
3. The resident plan of care must contain all interventions to prevent an elopement and all staff must be made aware of those interventions.
4. Any resident actively exit seeking, must have attempts made to involve them in an activity; take him/her for a walk, or remove him/her from the door area.
5. May use additional props to redirect the resident away from the exit doors.
6. The LN/ED needs to assess for the reasons for the exit seeking behavior and notify the MD.
7. There must be a plan of care meeting conducted with the ED, LN, RCC and family to help identify the reasons for the elopement and to implement interventions.
8. Identify the need for further psychiatric evaluation and assistance with the behavior planning.

9. If all plans and interventions are not effective, notify the Regional Vice President to consult on the safety of the resident in the community including consideration for alternative placement.

Elopement in Memory Care Policy and Procedure

POLICY

To train staff on our standard elopement drill at least quarterly and to have a procedure in place in the event of a missing resident.

PROCEDURE

1. Complete and keep a current list and picture of all dementia care residents identified as a high elopement and or a wandering risk.
2. In the event of a missing resident, staff shall notify their immediate supervisor and begin a thorough search of the entire community. This search shall include but is not limited to closets, under beds, and bathrooms, including showers
3. All windows must be checked during the search to ensure that they were not used as the exit route.
4. The Executive Director or designee shall be notified immediately.
5. The Executive Director or designee shall notify all managers to be on alert if additional assistance is needed.
6. Staff shall thoroughly research all areas, even if previously searched.
7. Automobiles must be searched by staff and volunteers in surrounding neighborhoods. Searching staff members are to stay in touch by cell phone and are to report back to the community regarding their status in 15 minutes.

If Resident is still missing after completion of the above

1. Notify sheriff/police Department via 911
2. Provide local law enforcement with the following information:
    - The time that the resident was last seen, by whom, and what they were doing
    - Picture of the resident
    - The Clothing they were wearing when last seen
    - Any physical identifying information
    - Information about health status, medication or medical needs
    - Information about nicknames or typical behavior
3. Inform Family/legal representative and resident physician.
4. Continue to work with law enforcement per their directions.
5. Notify the Community RVP, who then will notify VP of Operations.

7420 Bridgeport Rd., Suite 105
Portland, OR 97224
(503) 443-1818- office
(503) 443-1919- fax

WHEN RESIDENT RETURNS TO THE COMMUNITY

1 Obtain an updated medical evaluation of the resident if seen at a hospital and initiate any new orders.
2 If not seen at hospital, Health Service Director shall complete a full assessment of resident.
3. Establish extra staffing for the resident, including overnight, until reassessment is completed.
4. Place resident on ALERT and complete necessary documentation.
5. Update service plan for new interventions to ensure safety of resident.
6 Schedule an in-service within 48 hours to review the event and ensure that procedures were followed, implementing any necessary changes.
7 Verify that resident is included on the high risk of elopement list and add resident if not listed
8 Notify RVP of outcome and health status of the resident
9. The Executive Director must notify the state licensing agency per licensing requirements.
10. The Executive Director, Health Services Director, Area Nurse and RVP will access communities continued ability to meet resident's needs.

7420 Bridgeport Rd., Suite 105
Portland, OR 97224
(503) 443-1818- office
(503) 443-1919- fax

Guideline

Event Reporting

Nurse

Documentation of any event that has potential for concern for any tenant, staff, or visitor

- An event of concern may be: injury, potential for injury (i.e. fall), elopement, abnormal behavior, etc. A major injury shall be defined as: an injury that results in death, admission to a higher level of care, requires law enforcement intervention, emergency mental health treatment, report of dependent adult abuse, elopement, or medication errors of prescription meds
- Incident report will be completed by the staff member that first is made of aware or is present at the time of the event. Event will be documented in permanent record by RN who does assessment after incident. Report will initially be kept in binder in nursing office for 90 days then to incident report file.
- Incident report must be completed by staff before leaving the building at the end of their shift
- Staff is to contact Nurse and / or manager with each/any incident / event during their shift at the time of the event/incident
- Completed incident reports will be left in nursing office
- RN will follow up with evaluation in a timely manner
- If tenant is a member of our Gardens, family members need to be notified of incident by RN / Manager
- Any major injuries will be reported to Department of Inspections and Appeals within 24 hours or next business day (DIA may be notified by phone, fax, or e-mail). Legal guardians will be notified of the event/incident within in 24 hours of the event/incident.

- **"Major incident"** means an occurrence involving a consumer during service provision that:
    1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital:
    2. Results in the death of any person
    3. Requires emergency mental health treatment for the consumer;
    4. Requires the intervention of law enforcement;
    5. Requires a report of dependent adult abuse pursuant to Iowa Code section 235B 3;
    6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in "1","2","3" or (NOTE: Only ones that lead to 1,2,3 are major incidents and are reported to bureau, others are minor incidents which are not to be reported to bureau but documented as minor)
    7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

The following are additional response and documentation of an event if the resident is a member of the Frail Elderly Waiver or Intellectual Disability Waivers.

For residents under the Frail Elderly Waiver or Intellectual Disability Waivers: A "Major incident" will be reported to Department of Human Services, and/ or Case Manager/Service Worker as indicated by the end of the next calendar day. DHS will be notified online through the IMPA system. Legal guardians will be notified of the event/incident within 24 hours of the event/incident.

The consumer shall be notified within 24 hours of an event/incident took place outside the provision of providing cares. Follow up reports will be made to case manager as they request for any major injury. *Reminder: All major injuries must also be reported to Department of Inspections and Appeals within 24 hours or next business day (DIA may be notified by phone, fax, e-mail or online). Legal guardians will be notified of the event/incident within in 24 hours of the event/incident.*

The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report

- A **"Minor" incident** is an occurrence involving a consumer during service provision that is not a major incident and that:
  1. Results in the application of basic first aid;
  2. Results in bruising;
  3. Results in seizure activity;
  4. Results in injury to self, to others, or to property;
  5. Constitutes a prescription medication error.

A minor incident must be documented using the Event Reporting Form and must be completed before the staff member leaves the building before the end of their shift.

The staff must contact the Nurse, and/or Manager with any incident or event at the time of the incident/event The completed report must be kept in a binder in the nursing office for one year and then to incident report file. For all incidents a notation will be made in the individual resident file.

Follow these steps for any event/incident that is out of the normal daily activity for a resident such as:

- Falls
- Sliding to floor
- Skin abrasion
- Skin tears
- Cuts
- Injuries
- Etc.

1. Complete an incident report
2. Notify on call RN of falls
3. Update 24 hour report sheet on incident/event
4 Report off to oncoming shift incident/event
5. Put completed incident report in Health Care Coordinator office
6. Health Care Coordinator will be responsible for updating resident care plan
7. Health Care Coordinator will try new/un-tried interventions, not just repeating same intervention
    - Intervention needs to be resident specific
    - Work from least restrictive intervention, when this has not prevented additional events increase restrictive interventions
8 Health Care Coordinator must complete pertinent assessment as needed/applicable:
    - Fall risk assessments
    - Skin condition report/skin assessment
    - Neuro assessments
    - Plan assessments

Tracking and analysis

Nurse will track incident data and analyze trends to assess the health and safety of residents served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.